| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155729 | A. BUILDING 01<br>B. WING | 09/14/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ADAMS HERITAGE | 12011 WHITTERN RD<br>MONROEVILLE, IN 46773 |

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| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 09/14/15<br><br>Facility Number: 002549<br>Provider Number: 155729<br>AIM Number: 200289420<br><br>At this Life Safety Code survey, Adams Heritage was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, areas open to corridor and hard wired smoke detectors in the resident rooms. The facility has a capacity of 61 and had a census of 51 at the time of this survey. | K 0000 | Preparation and execution of this plan of correction<br>does not constitute admission or agreement by<br>provider to the truth of the facts alleged or the<br>conclusions set forth in the Statement of Deficiencies<br>rendered by the reviewing agency. The Plan of<br>Correction is prepared and executed solely because<br>it is required by the provisions of federal and state law.<br>adams-Heritage maintains that the alleged<br>deficiencies do not individually or collectively<br>jeopardize the health and/or the safety of its residents<br>nor are they of such character as to limit the<br>provider's capacity to render adequate resident care.<br>Furthermore, adams-Heritage asserts that it is in<br>substantial compliance with regulations governing the<br>operation of long term care facilities, and this Plan of<br>Correction in its entirety constitutes this provider's<br>allegation of compliance and, thereby, we request<br>resurvey to verify such as of September 21, 2015.<br><br>**Further, we request desk review (paper compliance)** | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered were a detached shed used for storage of maintenance equipment, parts and the facility's bus. Another detached shed used for storage of maintenance supplies.<br><br>Quality Review completed 09/15/15 - DA | | **for compliance, if acceptable.**<br><br>Completion dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated accomplished corrective action. These do not necessarily chronologically correspond to the date that Adams Heritage is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary. | |
| K 0025<br>SS=F<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4<br>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice | K 0025 | K025 ***1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?*** Mechanical rooms and fire alarm panel room are always locked. Both all Penetrations will be sealed by September 25, 2015. ***2. How*** | 09/25/2015 |

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| | could affect all residents in 5 of 5 smoke compartments.<br><br>Findings include:<br><br>Based on observations during a tour of the facility with Environmental Services Supervisor on 09/14/15 between 9:45 a.m. and 11:30 a.m., the following ceiling smoke barrier had unsealed penetrations or penetrations sealed with an un-rated material:<br>a) In the ceiling of the mechanical room on Prairie Pass there were 3 penetrations around wires and conduits filled with a white caulk.<br>b) In the ceiling of the mechanical room in the dining room there were 3 penetrations around wires and conduits filled with a white caulk.<br>c) In the ceiling of the mechanical room in Heritage Hall there were 2 penetrations around wires and conduits filled with a white caulk.<br>d) In the ceiling of the mechanical room on Timber Trail there were 3 penetrations around wires and conduits filled with a white caulk.<br>e) In the ceiling of the fire alarm panel room there were 2 unsealed penetrations around wires and conduits measuring half of an inch in size.<br>Based on interview at the time of observation, the Maintenance Director | | ***other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** None identified. Mechanical rooms and fire alarm panel room are always locked. Penetrations will be sealed by September 25, 2015. ***3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** Monthly environmental rounds are performed to make sure all penetration are identified and sealed correctly. ***4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?*** Continue Monthly environmental rounds will be preformed to make sure penetration are identified and sealed correctly with fire rated caulking. ***5. By what date the systemic changes will be completed?*** September 25, 2015 | |

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| | acknowledged and provided the measurements of the penetrations. Also, the Maintenance Director did not know if the white caulk was an approved material and did not have the documentation to show if the foam met the requirements for use in through penetration fire stop systems.<br><br>3.1-19(b) | | | |
| K 0029<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br>Based on observation and interview, the facility failed to ensure 2 of 2 a hazardous areas, such as a boiler room, was smoke resistive. This deficient practice could affect 35 residents in 2 of 5 smoke compartments.<br><br>Findings include:<br><br>Based on observation during a tour of the | K 0029 | K029 ***1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?*** The main Mechanical room and Kitchen Mechanical room are always locked. All Penetrations and unsealed gap will be sealed by September 25, 2015. ***2. How other residents having the potential to be affected by the*** | 09/25/2015 |

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| | facility with the Environmental Services Supervisor on 09/14/15 between 9:45 a.m. and 11:30 a.m., the fowling hazardous areas had unsealed penetrations or penetrations sealed with an un-rated material:<br>1) In the kitchen mechanical room, which contained a hot water heater, there was a half inch unsealed gap around a heating duct.<br>2) In the kitchen mechanical room, which contained a hot water heater, there were two penetrations sealed with a white caulk.<br>3) In the main mechanical room, which contained a hot water heater, there were ten penetration sealed with a green caulk.<br>4) In the main mechanical room, which contained a hot water heater, there were two unsealed penetrations measuring two inches through conduit which contained wires.<br>Based on interview at the time of observation, the Environmental Services Supervisor acknowledged and provided the measurements of the penetrations. Also, the Maintenance Director did not know if the white or green caulk was an approved material and did not have the documentation to show if the foam met the requirements for use in through penetration fire stop systems.<br><br>3.1-19(b) | | ***same deficient practice will be identified and what corrective action(s) will be taken?*** None identified. Mechanical rooms and fire alarm panel room are always locked. Penetrations will be sealed by September 25, 2015. ***3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** Monthly environmental rounds are performed to make sure all penetration are identified and sealed correctly. ***4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?*** Continue Monthly environmental rounds will be preformed to make sure penetration are identified and sealed correctly with fire rated caulking. ***5. By what date the systemic changes will be completed?*** September 25, 2015 | |

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| K 0062 SS=B Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 2 sprinkler heads in the Heritage Hall mechanical room was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice can affect up to 35 residents using Heritage Hall.<br><br>Findings include:<br><br>Based on observation during a tour of the with the Environmental Services Supervisor on 09/14/15 at 10:25 a.m., one of two sprinkler heads in the | K 0062 | K062 ***1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?*** Shambaugh & Sons, Inc will correct the sprinkler head from touching the insulated water line. A pendant for the sprinkler was ordered. ***2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** None identified. ***3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** Monthly environmental rounds are performed to make sure all sprinklers have minimize obstructions to discharge, ***4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?*** Monthly environmental rounds are performed to make sure all sprinklers have minimize obstructions to discharge, ***5. By what date the systemic changes will be completed?*** | 10/02/2015 |

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| | Heritage Hall mechanical room was touching an insulated water line in such a way the spray pattern of the sprinkler head would not provide adequate coverage of the room. Based on interview at the time of observation, it was acknowledged by the Environmental Services Supervisor that the sprinkler head was up against a pipe and would obstruct the spray pattern of the sprinkler.<br><br>3.1-19(b) | | October 2, 2015 | |